

## **Appendix 2: Methods**

### ***Recruitment***

There were no suggestions for specific participants from the Ontario Critical Care COVID-19 Command Centre (OCCCCC) or from the research coordinator.

As is often the case for snowball sampling, determining a numerical recruitment rate for the study is not possible. The total number of people that the authors had access to for recruiting is difficult to know, as potential participants received emails from OCCCCC regional leads, who in turn forwarded the recruitment email to their local, hospital-level leads. Further, we asked participants to forward along the recruitment email to their colleagues, and we are uncertain how many people each participant forwarded the email to. Therefore, the authors could not accurately estimate the total number of emailed participants. Additionally, the number of staff involved in implementation planning differed among regions and hospitals.

### ***Eligibility***

We did not use a screening tool to gauge knowledge and participation in the ESoC.

### ***Data Collection – Demographic Surveys***

The survey was administered by having the research coordinator share his screen over zoom and go over the questions with the participant. The research coordinator on his end completed the survey based on the participants' input.

### ***Data Collection – Interview Guides***

Broadly, interview guides began with introductory questions about the participant's professional background and current role. Next, questions were asked about the participant's

general perspective on the ESoC. Then, questions were asked about supports and ethical concerns. The guide then transitioned to questions regarding improvements.

### ***Confirmability, Credibility, and Transferability***

We ensured that our study was confirmable, credible, and transferable by including the following methods and processes in our study.(1,2)

Confirmability	<ul style="list-style-type: none"> <li>- Rich quotes were provided in Table 2., depicting subthemes reported in this manuscript.</li> <li>- Interviewers engaged in reflexivity through the completion of post-interviewer forms. These forms included interviewer reflections on their biases, assumptions, and lessons learned for future interviews. We discussed the content of these forms at our weekly meetings.</li> <li>- The authors maintained an audit trail, including interview transcripts, interviewer forms, coding iterations, meeting minutes, and drafts of the final reports.</li> </ul>
Credibility	<ul style="list-style-type: none"> <li>- Interviews started with introductory questions, allowing for the development of rapport before getting into the more pertinent questions.</li> <li>- The interviewers regularly engaged in peer debriefing with each other and the broader study team to discuss their findings.</li> </ul>
Transferability	<ul style="list-style-type: none"> <li>- Researchers engaged in purposive sampling, as well as snowball sampling.</li> <li>- Researchers reached thematic saturation.</li> </ul>

	<ul style="list-style-type: none"> <li>- The themes and suggestions in our study are likely broadly relevant to implementing a triage plan or standard of care in any population affected by an infectious pathogen with similar properties.</li> <li>- Our learnings are more relevant for ongoing major surge events than mass casualty events, such as those caused by a natural disaster</li> </ul> <p>We present subthemes, suggestions, and quotes regarding features of the ESoC implementation specific to Ontario, and, thus, our findings may have limited transferability to other settings.</p>
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### ***References:***

1. Guba EG, Lincoln YS. Competing paradigms in qualitative research. *Handbook of qualitative research*. 1994;2(163–194):105.
2. Anney VN. Ensuring the quality of the findings of qualitative research: Looking at trustworthiness criteria. *Journal of emerging trends in educational research and policy studies*. 2014;5(2):272–81.